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Correspondence

INTELLIGENCE OF PATIENTS IN SUBNORMALITY HOSPITALS

DEAR SIR,

My letter (*Journal*, June 1965) referred exclusively to the question of demarcation between the legal categories of "Subnormality" and "Severe Subnormality". In their subsequent letter (December 1965), Messrs. Castell and Mittler deal with this under their third heading, which, however, reads: "3. The borderline between subnormality and severe subnormality *of intelligence*"; this, of course, begs the whole question, since the words "severe subnormality of intelligence" do not appear in the Act.

Like Dr. Bavin and Dr. Shapiro, I pointed out that the authors were inviting us to ignore the plain wording of the law and to substitute for the criteria it prescribes a particular intelligence score. The authors, in their reply, make no attempt to answer this criticism, but after mentioning it pass on at once to an argument about the views of the Royal Commission. This I will come back to presently, but first I must repeat the fundamental point at issue: the Act does not specify a separate, lower intelligence ceiling for "Severe Subnormality", but rests its definition on clinical and social facts; the authors advise that we should proceed as if a separate ceiling *were* specified; by what right do they do this?

From several paragraphs it would appear that the authors believe that the definition "is incapable of living an independent life or of guarding himself against serious exploitation", etc., refers to the patient's ultimate condition after all possible treatment or training has been given, instead of (as it does) to his condition at the time he is classified. For they consider it wrong that patients should be classed as "severely subnormal", if the I.Q. suggests that they have "the *potential* ultimately to leave hospital and lead a more or less independent life". Is this not like saying that no one should be classed as "ill" if he has the potential to get well? More technically, do the authors not know that psychiatrists are constantly certifying to the Court of Protection that a mentally ill patient "is incapable of managing his affairs"; would they interpret this as meaning that the patient is incurable?

Now as to the Royal Commission, which was first mentioned by the authors in the following context: "Severe Subnormality" was being given a wider interpretation than that advocated by the Royal Commission; the category had implications of "very low intelligence". I contended that the views of the Commission were here misrepresented, and quoted the relevant passages; but the authors say that two sentences which I omitted destroy my argument. I will therefore quote these sentences, together with those immediately preceding and following:

(1) "The broad dividing line between the patients whom we call severely subnormal and those we call psychopathic comes in the middle range of what is now called feeble-mindedness. We would consider a mental age below 7½ to 9 or an I.Q. below 50 to 60 as strongly indicative of a personality so seriously subnormal as to make the patient incapable of living an independent life. But in some cases it may be true to say that patients are seriously subnormal and incapable of living an independent life even if their I.Q. is, say, 60 or even higher if they have other defects of personality . . ."

(2) "The diagnosis in each case must be a matter of medical judgment, and we consider that the term 'severely subnormal' would be readily understood without more precise definition beyond an indication that it always involves marked limitation of intelligence as well as other personality defects. We doubt if it would be safe to assume that less than about a half to two-thirds of the patients in mental deficiency hospitals at present classified as feeble-minded would come into the severely subnormal group."

Your readers may judge for themselves.

The Commission went on to say: "The rest of the patients classified as feeble-minded would be in our psychopathic group." Messrs. Castell and Mittler hold that the introduction into the Act of the "Subnormality" category made "an important difference"; they do not specify what this was, but presumably they are suggesting that the upper limit of "Severe Subnormality" was thereby lowered. I can find no evidence for this: the Commission itself had divided its excessively wide "psychopathic" category into "feeble-minded psychopaths" and disordered personalities of normal intelligence, and it was the general view that these should be separately named in the Bill.

On the other hand, as I pointed out previously, the social upper limit for "Severe Subnormality" was actually *raised* during the passage of the Bill. In the House of Lords fears were expressed that

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patients classified as "Subnormal" might have to be discharged at the age of 25, although they were unfit (or not yet fit) to live in the community because of their inability to guard against exploitation. The definition of "Severe Subnormality" was therefore altered at this stage in order to include such patients. Here again, no one was thinking of incurability: it was a question of allowing time for further training with a view to independence.

In the conclusion to their letter the authors stress the need for greater agreement on the principles of classification. This, of course, is a matter for those working in this field; but I would suggest that any agreement on the use of legal (as distinct from clinical) terms must be within the bounds of what is stated in the law.

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DEAR SIR,

Drs. Castell and Mittler (*Journal*, December 1965) probably do not receive in their departments of psychology the official directives of the Ministry of Health. If they did, they might qualify their statement that "the Act's new classifications are indeed being used for clinical and administrative purposes".

The Ministry, which spawned 'mental subnormality', speaks with several voices. It is true that I occasionally receive from it communications addressed to me as "Medical Superintendent of a hospital for the subnormal and severely subnormal", the Ministry forgetting on these occasions that I might have a few psychopaths as well. The Statistics Branch of the Ministry ask for details of patients not only as "subnormal" or "severely subnormal", but also classified according to the type of "mental retardation".

The Architects' Department of the same Ministry has, however, its own views (Hospital Building Note No. 30), and must be congratulated on producing a classification unlike any other and probably unique. It is:

1. Severely subnormal, low-grade
2. Severely subnormal, medium-grade
3. Subnormal, low-grade
4. Subnormal, high-grade

To those who speak the English language all this may be sensible, unambiguous and crystal-clear. Foreigners to whom it is explained regard it as madness. As Dr. Bavin (*Journal*, June and September) and I (*Brit. med. J.*, 30 January, 1964) have suggested, could not the hideous and inaccurate terms "subnormal" and "severely subnormal" be reserved for those few patients who are legally detained? We might then get a little way out of the bog.

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CRYPTOMNESIA AND PLAGIARISM

DEAR SIR,

In his most interesting and valuable paper on "Cryptomnesia and Plagiarism" (*Journal*, November 1965, p. 1111), Dr. F. Kräupl Taylor mentions two points which, although peripheral to his main theme, are of sufficient general interest to justify further comment.

Firstly, he says that the term "cryptomnesia", in its use to denote the emergence of hidden memories in trance states, has fallen into such disrepute that it should now be restricted to "the appearance in normal consciousness of memories which are not recognized as such subjectively". It was, however, spiritualistic interpretations of trance phenomena which fell into disrepute, rather than the phenomena themselves. Also, hidden memories which emerge in trance states are just as "cryptomnesic" as those which emerge in normal consciousness—whatever the dictionaries may say. The proposed new use of the term would appear, therefore, to be too restrictive.

Secondly, Dr. Taylor asserts that "more sober" students of cryptomnesic phenomena "discount" the belief that a trance medium can reproduce the memories of dead people. Confidence in discounting this belief is based, however, not on factual evidence which disproves it, but on confidence in the conceptual framework of currently orthodox psychological theory—which excludes its credibility on *a priori* grounds. Moreover, if telepathic phenomena exist, this disputed ability of trance mediums would be an obvious possibility, requiring no spiritualistic hypothesis. Indeed, some students of the recently-published Cummins-Tennant automatic scripts, and of Professor C. D. Broad's searching commentary on them (Toksvig, 1965), may understandably conclude that there is weighty evidence to support it. Really sober students will hesitate, no doubt, to accept this belief as having been conclusively established, but they will also, surely, be sufficiently sceptical of speculative theory to refuse to "discount" it.

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